STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

OFFICE OF PLAN OVERSIGHT
DIVISION OF PLAN SURVEYS

FINAL REPORT OF THE DENTAL SURVEY

of

CALIFORNIA DENTAL NETWORK, INC.

Date Issued to Plan July 13, 2001

Date Issued to Public July 26, 2001

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SECTION I. INTRODUCTION AND SURVEY PROCEDURES

As required by Section 1380 of the Knox-Keene Act, the Department of Managed Health Care (the "Department") conducted an on-site dental survey of California Dental Network, Inc. (the "Plan") on November 28, 29, 30, and December 1, 4, 5, 6, and 7, 2000, and February 13, 2001.[1] The Department also conducted an exit conference on March 14, 2001. A Preliminary Report was issued to the Plan on April 3, 2001, and the Plan was required to submit a response within 45 days of its receipt.

This Final Report describes the survey findings and required corrective actions as they were reported in the Preliminary Report, a summary of the Plan's compliance efforts as reported in the Plan's 45-day response to the Preliminary Report, the Department's findings concerning the Plan's compliance efforts, and the Department's determination as to whether deficiencies were corrected within 45 days of the Plan's receipt of the Preliminary Report.

Any member of the public wanting to read the Plan's entire response and view the Exhibits attached to it may do so by visiting one of the Department's offices. One copy of the Summary Report of the Final Report is also available free of charge to the public by mail. Additional copies of the Summary Report and copies of the entire Final Report and Plan's response can be obtained from the Department at a cost of 25 cents per page. Final Reports are available on the Department's web-site: www.dmhc.ca.gov.

The Plan may file an addendum to its response at anytime after the Final Report is issued to the public. Copies of the addendum also are available from the Department at the cost of 25 cents per page. Persons wanting copies of any addenda filed by the Plan should specifically request the addenda in addition to the Plan's response.

During this survey, the Department reviewed the areas required by Section 1380(a), which include the following:

(1) the Plan's procedures for obtaining health services;
(2) the procedures for regulating utilization;
(3) peer review mechanisms;
(4) internal procedures for assuring quality of care; and
(5) the overall performance of the Plan in providing health care benefits and meeting the health needs of subscribers and enrollees, including the Plan's organizational and administrative capacity to provide healthcare services, availability and accessibility of care, the Plan's grievance and appeals system, and public policy participation.

[1]References throughout this report "Section _____" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as amended [California Health and Safety Code section 1340 *et seq*. ("the Act")]. References to "Rule _____" are to the regulations promulgated pursuant to the Act [Title 28 of the California Code of Regulations, beginning at Section 1300.43 ("the Rules")], and transferred to the Department of Managed Care pursuant to Health and Safety Code Section 1341.14.

The Department also reviewed the Plan's pre-survey documents that the Plan submitted in response to the Department's survey notification letter. The pre-survey information included information regarding the Plan's enrollment, provider network, benefits, organization, treatment authorization process, grievance system, and quality assurance program.

At the Plan's administrative offices, the Department reviewed the following: (1) 22 grievances and appeals filed at the Plan; (2) the Plan's grievance and appeal procedures; (3) results of Plan audits of provider offices; (4) information from the Plan's quality assurance system, including minutes of the committees responsible for Plan quality management activities; (5) credentialing information for Plan providers; (6) the Plan's treatment authorization process, including 25 specialty referral requests; and (7) Plan information for providers describing Plan policies and benefits.[2] The Department also conducted interviews with staff responsible for these areas.

The Department also reviewed charts of enrollees who had received general dental care at three of the Plan's participating general dental offices. The Department reviewed a total of 30 patient charts for the three general practice offices. Further, the Department reviewed grievances that had been filed in the three offices.

The Department then conducted a structural review, i.e., a review of infection control, emergency safety, radiological safety, and access, at one Plan general dental office.

SECTION II. RESPONSE REQUIREMENTS AND REPORT PROCESS

ALL DEFICIENCIES CITED IN THE PRELIMINARY REPORT REQUIRE CORRECTIVE ACTION BY THE PLAN.

The Preliminary Report required the Plan's response and follow up action on all deficiencies cited. The Department specified CORRECTIVE ACTIONS in cases where factual findings of a deficiency constitute a violation of the Knox-Keene Act. The Department required the Plan to implement all CORRECTIVE ACTIONS in the manner prescribed by the Preliminary Report and submit evidence that the required action had been implemented or was in the process of being implemented when the Plan submitted its 45-day response.

Where the Survey Report describes areas in which the survey team found a required process or result is unsatisfactory but the facts do not support a violation of the Act, the Department set forth "Findings" and "Recommended Actions." These are set forth under the section entitled "Additional Findings and Recommendations for Consideration."

For each deficiency cited in the Preliminary Report, the Plan was required to submit the following information: (1) the Plan's response to the Department's findings of deficiency; (2) a comprehensive description of the Plan's corrective action; (3) whether the Plan's corrective action will be fully implemented by the time the Plan submits its response; (4) if fully implemented, revised policies and procedures, where applicable, including clean and red-lined

[2] Practice and patient identifying information for the cases mentioned in this report are set forth in the Appendix of this report for the Plan's review, which will be held confidential pursuant to Section 1380(d).

versions, and evidence that the policy revisions have been implemented; (5) if not fully implemented, the name(s) and title(s) of person(s) at the Plan who will be responsible for implementing the corrective action, a time-schedule for implementation, policies and procedures required for implementation (including clean and red-lined versions of any revised policies and procedures), and a list of the documents or other evidence the Plan will submit to the Department for the Department's follow-up review that will show the deficiency has been corrected.

According to Section 1380(h)(1), the Department is normally required to publish a Final Report and issue it to the public not more than 180 days from the conclusion of the on-site survey. The Department normally sends the Final Report to the Plan ten days before the Department issues the Report to the public. The Department will issue a Summary of the Final Report to the public at the same time it issues the Final Report to the public. The Plan may submit additional responses to the Final Report and the Summary Report at any time. The Plan's submissions will also be made available to the public, unless the Plan makes a request for confidentiality.

The Department will conduct a Follow-up Review within 18 months of the date of the Final Report to determine whether the deficiencies identified by the Department have been corrected. *See* Health and Safety Code Section 1380(i)(2). PLEASE NOTE that the Plan's failure to correct deficiencies identified in the survey report MAY BE GROUNDS FOR DISCIPLINARY ACTION AGAINST THE PLAN as provided by Health & Safety Code Section 1380(i)(1).

This Report focuses on deficiencies found during the medical survey. Only specific areas found by the Department to be in need of improvement are included in the report. Omission of other areas of the Plan's performance from the report does not necessarily mean that the Plan is in compliance with the Knox-Keene Act. The Department may not have surveyed these other areas or may not have obtained sufficient information to form a conclusion about the Plan's performance.

SECTION III. OVERVIEW OF THE PLAN'S ORGANIZATION AND HEALTH CARE DELIVERY SYSTEM

DATE PLAN LICENSED:

The Plan was originally licensed on May 12, 1988 as Alternative Dental Care of California, Inc. The Plan was acquired by its current parent company, Pacific Dental Network, Inc. in May 1998, and changed its name to California Dental Network, Inc. in June 1998. Prior to the name change, and under the former ownership, the Plan's membership was rolled over to United Concordia Dental Plans of CA, Inc. (dba Mida Dental), which was also under the same ownership. The Plan's initiation of membership under its current ownership and name began in July 1998.

FOR PROFIT/NON-PROFIT STATUS: For-profit

DELIVERY MODEL AND PROVIDER NETWORK:

In general, enrollees select contracting general dentists from among the Plan's general dental provider network for purposes of obtaining primary dental care. The Plan's contracting general dentists are compensated on a capitated basis. Although the Plan also contracts with dental specialists, the Plan does not assume financial risk for dental specialty services. In general, subject to referral from enrollees' general dentists and the Plan's prior-authorization, enrollees may access contracting dental specialists on a discounted fee-for-service basis wherein the enrollees are responsible for the entire discounted fee. The Plan's dental provider network is comprised of 747 contracting general dentists and 342 contracting dental specialists, including 178 orthodontists, 15 pedodontists, 55 periodontists, 73 oral surgeons, and 21 endodontists, across the Plan's overall service area.

NUMBER OF ENROLLEES:

Approximate enrollment*:	4,300 as of January 1999; 14,500 as of July 1999; 22,000 as of January 2000; and 29,500 as of July 2000

*since acquisition by current owner and change to current name

SECTION IV. SUMMARY OF DEFICIENCIES

The Department has found the following deficiencies which the Plan is required to correct:

Plan Organization

Deficiency 1: The Department found that the Plan lacked adequate staffing to conduct the Plan's Quality Assurance (QA) Program and has not implemented a mechanism to conduct utilization monitoring. [Section 1367(g), Section 1370, Rule 1300.67.3 (a)(2), and Rule 1300.70(b)(2)(E)]

Internal Procedures for Assurance Quality of Care and Peer Review Mechanisms

Deficiency 2: The Plan did not implement a Quality Assurance Program that ensures a level of dental care meeting professionally recognized standards and that dental quality problems are identified and corrected at the Plan's general dental offices. [Section 1367(b), Section 1370, Rule 1300.67.3(a)(2), Rule 1300.70(a)(1), Rule 1300.70(b)(1)(A) and (B), and Rule 1300.70(b)(2)(E)]

Deficiency 3: The Plan did not implement a Quality Assurance Program for its orthodontic offices to assure that services provided to Plan enrollees meet professionally recognized standards of care and that quality problems are identified and corrected. [Section 1370, Rule 1300.67.3(a)(2), Rule 1300.70(a)(1), Rule 1300.70(b)(1)(A) and (B), and Rule 1300.70(b)(2)(E)]

Deficiency 4: The Plan did not have an appropriate range of dental specialist providers involved in quality assurance activities or on QA review committees. [Section 1370 and Rule 1300.7(b)(2)(E)]

Deficiency 5: The Plan has not implemented a utilization monitoring system meeting Knox-Keene Act requirements. [Section 1370, Rule 1300.70(c), Rule 1300.70(b)(2)(H)2.]

Access and Availability

Deficiency 6: The Plan lacks arrangements that assure reasonable accessibility to dental care throughout the Plan's service area because the Plan lacks specialty providers in service areas in which the Plan is licensed to operate. [Section 1367(e)(1) and Rule 1300.67.2(e)]

SECTION V. SUMMARY OF THE PLAN'S EFFORTS TO CORRECT THE DEFICIENCIES

For the following deficiencies, the Department found that although the Plan had adequate corrective actions that appear sufficient to correct the deficiency, full implementation of those actions, and assessment of the effectiveness, will require more than forty-five (45) days:

Plan Organization - Deficiency 1;
Procedures for Assuring Quality of Care and Peer Review Mechanism – Deficiencies 2,4,5; and Access and Availability – Deficiency 6.

For the following deficiency, the Department found that the Plan's corrective action plan requires further revision in order for the Plan to assure the Department that it is capable of correcting the deficiency:

Internal Procedures for Assuring Quality of Care/Peer Review Mechanism – Deficiency 3;

For each of these deficiencies, the Department will review the Plan's implementation efforts to correct them at the time of the Department's Follow-Up Review. Also, for each of these deficiencies, the Department requires that the Plan address all outstanding issues described under the subsection entitled "Department Finding Concerning the Plan's Compliance Effort."

By notice of this Final Report, the Department is notifying the Plan that the Plan must address and implement all required corrective actions on a timely basis and prior to the Department's Follow-Up Review.

SECTION VI. DISCUSSION OF DEFICIENCIES AND CORRECTIVE ACTIONS

A. PLAN ORGANIZATION

Deficiency 1: The Department found that the Plan lacked adequate staffing to conduct the Plan's Quality Assurance Program and has not implemented a mechanism to conduct utilization monitoring. [Section 1367(g), Section 1370, Rule 1300.67.3(a)(2), Rule 1300.70(b)(2)(E)]

The Department found that the Plan lacked arrangements with an orthodontic consultant capable of rendering a decision concerning the quality review program for the Plan's orthodontic offices. The Plan does not have an orthodontic consultant to conduct quality assurance reviews of offices providing orthodontic services to Plan enrollees or to review grievances filed by enrollees concerning the quality of orthodontic care. See "Procedures for Assuring Quality of Care and Peer Review Mechanisms"/Deficiency 3, below.

The Department also found that the Plan did not have adequate staff to evaluate utilization data collected as a part of the Plan's Quality Assurance Program and has not implemented a utilization management process. Although the Plan does collect some encounter data, the Department's review found that the encounter data are stored in boxes and are not used in any way to monitor utilization of services. During interviews with Plan staff, a lack of personnel was given as one reason that encounter data were not being tabulated and summarized for monitoring utilization of services.

The Plan has not compiled utilization data and has no method of evaluating services rendered by any provider in comparison to others or to Plan averages. There are no summary utilization reports available for quality assurance review or assessment. The Plan therefore lacked an adequate number of staff to compile and evaluate utilization data as described in the Plan's Quality Assurance Program, "Utilization Review". See "Procedures for Assuring Quality of Care and Peer Review Mechanisms"/Deficiency 8, below.

CORRECTIVE ACTIONS:

The Plan shall submit a corrective action plan, including the following:

(a) Evidence of an executed agreement with an orthodontic auditor licensed in California to conduct a program of quality assurance activities for the Plan's orthodontic program and to review quality of care grievances filed by enrollees concerning the quality of orthodontic services. The Plan's submission shall demonstrate that this orthodontist is qualified by training and experience to render an opinion regarding the quality of orthodontic services provided by Plan orthodontists. The Plan's submission shall include a revised organizational chart that includes the position of this orthodontic auditor. If the Plan's arrangements are with a Plan provider, the Plan's submission shall also describe mechanisms for auditing that provider's office; and

(b) A description of the Plan's staffing arrangements to ensure that the Plan's system for evaluation of dental services utilization, including the Plan's regular collection and reporting on encounter data, is effectively implemented. Also see Deficiency 6, below.

Plan's Compliance Efforts:

1-a- Response to Corrective Action:

In response to the Preliminary Report, the Plan submitted the following: (1) a copy of an executed agreement along with a Confidentiality Agreement with a board certified orthodontist who has agreed to serve as the Plan's designated Orthodontic Auditor and participate in the Plan's QA and Peer Review committees; and (2) a copy of the Plan's revised organizational chart for the portion of the organization under the Plan's Dental Director, which shows that the Plan's Orthodontic Auditor reports directly to the Plan's Dental Director. The Plan states in its response that a contract has been sent to the Plan's designated Orthodontic Auditor, which he is currently reviewing and is expected to return within the next few days. The Plan's response also states that the designated Orthodontic Auditor is not a Participating Plan Provider and therefore will not actually be treating plan members.

Also enclosed is a copy of the Orthodontic Auditor's credentials, that includes the following: resume; dental school diploma; license from the California State Board of Dental Examiners; Certificate from the American Board of Orthodontics; and Certificate from the California Association of Dental Plans as a Certified QA Auditor.

1-b – Response to Corrective Action:

The Plan's response states the following:

> "The Plan does not agree with the statement that it did not enter the encounter data because it did not have adequate staffing. The Plan chose not to implement the encounter data tracking system because the results would have been meaningless unless and until there are enough members in enough offices for a long enough period so that norms, standards or threshold level of utilization can be developed. By the end of 1998 the Plan only had 3,000 members and had been operating for 6 months. By the end of 1999 it had 14,000 but had only been operating for 18 months and most of the new members were enrolled in the latter half of 1999. Thus, without bench mark levels of utilization, how do you determine what constitutes over or under utilization? Also, with only small amounts of enrollment in each office, a statistical analysis is not reliable. For example, if an office only has one member and places a crown on that one member, than the office has a 100% utilization rate. Conversely, if the one member does not come into the office all year long, then office has a zero utilization rate, neither one of which is a reliable indicator of over or under- utilization.
>
> However, to ensure that the encounter data is now entered into the Plan's system in a timely manor, the Plan has:

Added a new part time person, and
Changed a part time person to full time, and
Restructured job assignments to ensure the timely input of encounter data.

See the Plans response to item # 6 for copies of the encounter utilization data reports that are based upon all encounter data received during the first quarter of 2001."

Department's Findings Concerning Plan's Compliance Efforts:

1-a – Response to Corrective Action:

When evidence of an executed contract with the orthodontic auditor is provided to the Department , the Plan's response will be considered adequate.

1-b – Response to Corrective Action:

The Plan states in its response that it wasn't a shortage of staffing, as stated by the Department, that caused a failure to enter encounter information and develop utilization data. The Plan states it was a planned action as it didn't have enough enrollees to make utilization data useful. The Department made its judgment about a lack of staffing, in part, on information gained from staff during scheduled interviews. The Plan has added staff and now has the capacity to process encounter data. The Plan has processed encounter data for the first quarter of 2001 and is now analyzing utilization information.

The Department finds that the Plan's corrective action plan is capable of correcting this deficiency.

Further Remedial Action:

The Plan shall submit a copy of the its executed contract with its Orthodontic Auditor. Upon receipt of this document, this deficiency will be considered corrected.

B. PROCEDURES FOR ASSURING QUALITY OF CARE AND PEER REVIEW MECHANISMS

Deficiency 2. The Plan did not implement a Quality Assurance Program that ensures a level of dental care meeting professionally recognized standards and that dental quality problems are identified and corrected at the Plan's general dental offices. [Section 1367(b), Section 1370, Rule 1300.67.3(a)(2), Rule 1300.70(a)(1), Rule 1300.70(b)(1)(A) and (B), and Rule 1300.70(b)(2)(E)]

A. The Plan's method for selection of patient charts did not adequately target patients who received a full range of basic dental services.

The Plan's Quality Assurance Plan contains the following description for chart selection for chart reviews: "Charts to be audited are selected from the current monthly eligibility list of the dental office. The total number of subscribers divided by 100 will determine the routine of chart selection. For example, if there are 595 subscribers, then 595 divided by 100 equals 5.95. Therefore, every sixth subscriber would be chosen for chart selection. From these subscribers, the office must pull the first ten available charts in the order in which the names were provided. The number of names required to reach ten charts will provide the patient utilization ratio. For example, if 30 names were required to obtain ten charts, divide ten by 30 to achieve a utilization ratio of 33 1/3%. In offices of less than 200 subscribers, divide by 50 to obtain the routine of chart selection."

The Plan did not follow the above procedure; in fact, the Plan did not dictate any procedure. The chart samples used in the three Plan audits reviewed by the Department were selected by the providers before the auditor arrived at the office to perform the audit. In the case of Practice #2, there were very few services provided to the patients and very little treatment to review. In Practice #2, ten patient charts were reviewed and there were ten examinations, five prophylaxes, two periodontal scalings, one crown prep (not cemented), one denture reline, one partial reline, one extraction and only one patient had multiple services. The one patient who had multiple services received four quadrants of scaling and root planning, one extraction, and one crown. In the case of Practice #3, the provider chose five children of the ten patients who were selected for quality of care review.

The Department found that having the practice select records allowed the practice to determine the patients included in the review. This has the potential of excluding records known by the practice to have problems in quality of care.

B. The Plan did not assure the Department that it had allocated sufficient resources to its Quality Assurance Program for conducting its audits of general dental offices.

The Plan Dental Director did not conduct office or chart reviews as part of the quality assurance program and the Plan did not contract directly with dental consultants to conduct the provider reviews. The Plan contracted with a consulting firm to conduct a specific number of quality assurance audits. Between March 23, 2000 and October 8, 2000, the Plan contracted to have 81

provider offices audited.

C. The Plan's audits of its general practice providers did not adequately identify deficiencies relating to quality of care identified by the Department.

The Department reviewed the same 30 patient charts from three practices that the Plan reviewed in its previous audits of those practices. The Department found instances where quality of care issues were not identified by the Plan auditor, as follows:

Practice #1:

Lack of documentation of soft tissue status on initial examination: The Department found that the provider did not evaluate soft tissue status in nine out of ten (90%) cases.

Failure to diagnose and treat dental decay: The Department found that the provider did not accurately diagnose dental caries in two out of seven (29%) cases that could be evaluated.

Failure to diagnosis and treat periodontal disease: The Department found that the provider did not diagnose periodontal problems in any of the five (0%) cases where the Department could observe periodontal problems on x-rays. When other pathosis was present, it was diagnosed in one out of two (50%) of cases.

Lack of documentation of oral hygiene instructions during prophylaxis: The Department found a notation that oral hygiene instructions were given in only two out of six (33%) of cases where the patient received a prophylaxis.

Practice #3:

Lack of documentation of existing conditions: The Department found that the provider did not document existing conditions such as missing teeth and restorations in five out of nine (56%) of applicable cases.

Lack of periodontal evaluation and periodontal treatment planning: The Department found that the provider did not evaluate periodontal status of the patient in one out of seven applicable cases (14%). In that case, periodontal problems the Department observed on x-rays were not diagnosed or treated.

D. The Plan failed to adhere to its QA audit schedule for contracting general dentists.

The Department's review found that the Plan did not conduct an audit program for its general dental offices in accordance with the Plan's Quality Assurance Program requirements. The Plan has conducted quality assurance audits of only 81 of its 747 general dental provider network offices. The auditing process for the 81 providers did not begin until March 23, 2000 and was completed on October 8, 2000. Although the Plan, under its current name and ownership, began accepting enrollees in July 1998, it did not begin quality assurance chart reviews until 21 months later. The Plan's QA Program description states that once an office has been "active" it will be

reviewed within 12 months and that the review will include Plan members' patient charts.

Thus, the Plan has not adhered to its schedule of auditing practices that have been active for 12 months. Additionally, the Plan does not have a plan or schedule for the quality assurance audits of the remaining providers to ensure that quality of care problems are identified and corrected.

CORRECTIVE ACTIONS:

The Plan shall submit a corrective action plan that demonstrates the development and implementation of a QA Program capable of accurately and consistently identifying dental quality issues at the Plan's general dental offices and ensuring that quality problems are corrected on a timely basis. The Plan's corrective action shall address, but not be limited to, the Plan's method for chart selection, the credentialing of the Plan's auditors who conduct QA audits, the adequacy of auditors to conduct the Plan's QA audit program, the Plan's efforts to ensure the accuracy of the auditors' chart audit findings, and the Plan's efforts to ensure adherence to its QA audit cycle schedule in accordance with its QA Program requirements.

As a part of the Plan's corrective action plan, the Plan's shall submit the following:

(a) Evidence that assures the Department that the Plan's present Quality Assurance Program chart selection method will be followed or file a revision to the present policy. The Plan shall assure the Department that the present or any proposed method of chart selection shall not allow the provider to pre-select the charts to be reviewed;

(b) Evidence that the Plan has allocated sufficient resources to its Quality Assurance Program for general dental offices. The Plan shall either submit evidence that its arrangements with the Plan Dental Director are sufficient to ensure the Plan has the capacity to conduct the Plan's QA Program, or the Plan shall submit evidence of any executed agreement (s) with dental auditor (s) required to conduct the Plan's QA Program;

(c) Evidence of additional training provided for professional personnel who conduct chart audits of Plan enrollees at provider offices. The training must be directed toward identifying all elements of patient care that may be deficient at provider offices, including the dental quality problems that the Department identified and that the Plan's auditor did not identify at selected practices, described above. If the Plan chooses not to use its present method of contracting with outside audit agencies, it must describe the training the Plan has given internal dental consultants; and

(d) The Plan shall submit a corrective action plan that ensures that dental care provided meets a professionally recognized standard of care and that problems are identified and corrected timely. The Plan's submission shall include provisions for re-audit within a reasonable time period for offices that are significantly non-compliant with professionally recognized standards of practice. The Plan's submission shall specify time frames for re-audit based upon the Plan's audit findings.

Plan's Compliance Efforts:

2-a - Response to Corrective Action:

The Plan's response states the following regarding its revised chart selection policy:

> "The Plan has amended its chart selection process to better obtain a sample of charts that is:
>
> 1) not selected by the provider (whenever practical) and
> 2) includes charts with significant quality issues for review.
>
> The process will include a pre-audit notification letter instructing the office on how to pull charts for the audit as well as the list of members the charts are to be pulled from.
>
> Enclosed are red-lined copies of the amended criteria, instructions to auditors and the audit notification letter to offices, contained in the QA plan Section VI."

Section VI of the Plan's revised QA plan sets forth the following regarding its chart selection criteria:

> "The office is sent an audit appointment letter, which includes the list of member names that audit charts are to be selected from, as well as appointment date and instructions for preparing for the audit. The auditor will be instructed to select ten charts form the 20 provided that fit the criteria of:
>
> 1. At least five charts are adult patients wit treatment plans that include more procedures than prophylaxis/hygiene/
> 2. At least five have completed treatment and have been seen for recall.
> 3. At least one pedodontic, one completed endodontic, one completed prosthodontic (crown, bridge, partial, denture) and one periodontic care are included."

2-b – Response to Corrective Action:

The Plan's response states the following regarding its CAP to assure that it has adequate licensed dentists to conduct its QA audit program: (1) The Dental Director, who is CADP certified and has experience in performing QA audits, will perform a portion of the facility audits; (2) Currently, there are only 21 offices that met the Plan's new threshold of 40 members that have not been audited, and most of these audits will be conducted by the Dental Director, who will spend an additional 16 hours a month dedicated to Plan operations, including QA audits; (3) The Plan will contract directly with QA auditors who are CADP certified and have valid California dental licenses to conduct its QA audit program; and (4) In the event that the Plan contracts with outside consulting firms to conduct QA audits, the Plan will require in its contract with the consulting firm that all auditors have valid California licenses in good standing and are CADP certified.

2-c - Response to Corrective Action:

The Plan's response sets forth the following regarding the training of auditors to address the accuracy of the QA audits:

> "As mentioned in 2b above, the Plan requires that all auditors have evidence of completing the CADP Q/A Auditor Certification Program. Additionally the Plan will provide to all Q/A Auditors specific training regarding the Plan's requirements, criteria and the type of problems not detected by prior audits that were identified by the Department.
>
> At the time of the DMHC review the Plan had just requested a 2nd audit of two facilities be performed by the consulting firm, using different auditors for each. Because of issues raised during the exit interview further audits through the consulting firm were suspended.
>
> The Dental Director and/or Quality Assurance Committee will conduct auditor calibration activities to verify the correctness of audits by asking recently audited offices to copy and send 1 to 3 of the audited charts, selected by the Dental Director, for review. Alternatively the Dental Director may elect to visit the dental office to review an entire audit.
>
> All newly contracted auditors will be sample reviewed from one of their first five audits and periodically thereafter. Auditors who do not show an adequate level of performance, as indicated by this sampling, will receive additional training by the Dental Director. Re-verification will be performed within five additional audits. Auditors who still do not perform adequately will be additionally trained or terminated."

2-d - Response to Corrective Action:

The Plan's response sets forth the following regarding its CAP to address adherence to its QA audit time frame standards:

> "The Plan has amended Section VII, "Combined Audit Scoring," of its QA plan to clarify its scoring and re-audit provisions and timeframes for offices that are significantly non-compliant. See the attached red-lined copy of Section VII. The Plan has also amended Section III, Provider Credentialing, Section IV, Quality Assurance Assessment, and Section V, Frequency of Review to clarify pre-audit procedures, initial audit timing and audit follow up procedures."

Within Section III, "Provider Credentialing," of the Plan's revised QA plan, the Plan sets forth the following regarding its audit and reaudit time frames:

> "An initial audit will be performed within 12 months of when 40 or more active patients are assigned to a newly contracted provider. This audit includes a review of the charts of assigned plan members. If this audit is acceptable, the facility will be scheduled for its

next periodic audit. The next audit will be scheduled within 24 months. If the audit reveals critical deficiencies, the provider is notified and a Corrective Action Plan (CAP) is requested. The Dental Director (DD) reviews all submitted CAPs and , based upon the nature of the deficiencies and the thoroughness of the CAP response, a decision will be made by the QAC or DD as to whether additional verification procedures (such as follow up visit by plan representatives or demand or follow up audit) are needed prior to the next provider audit. If a provider fails to adequately respond to a CAP request or if a re-audit s failed, the DD considers the matter. At the DD's discretion the facility may be re-audited, closed to new members or terminate. The DD may also defer a decision until the matter can be heard by the PRC."

Also refer to item 2b above under "Plan's Compliance Efforts."

Department's Findings Concerning Plan's Compliance Efforts:

2-a - Response to Corrective Action:

With respect to the Plan's response to correct the issues that the Department found with the Plan's chart selection for its QA audits, the Department finds that the Plan's corrective action plan is capable of correcting the deficiency.

2-b – Response to Corrective Action:

The Department's finds that the Plan's corrective action plan is capable of correcting the deficiency.

The Plan's response is adequate considering the Plan's small existing enrollment. The additional time commitment from the Dental Director should be adequate. If Plan enrollment expands significantly, the Plan must initiate its plans to contract with additional auditors as needed.

2-c - Response to Corrective Action:

With respect to the Plan's response to correct the issues that the Department found with the accuracy of the Plan's QA audits and the QA auditors' ability to identify dental quality problems at general dental offices, the Department finds that the Plan's corrective action plan is capable of correcting the deficiency.

2-d - Response to Corrective Action:

With respect to the Plan's response to correct the issues that the Department found with the Plan's adherence to its QA audit time frame standards, the Department finds that the Plan's corrective action plan is capable of correcting the deficiency.

The Department acknowledges that the Plan has taken steps to address the Corrective Action in the Preliminary Report. However, the Department finds that it will take additional time beyond

the date of the Plan's response for the Plan to correct this deficiency and to fully implement and document the changes required by the Plan's CAP.

Deficiency 3: The Plan did not implement a Quality Assurance Program for its orthodontic offices to assure that services provided to Plan enrollees meet professionally recognized standards of care and that quality problems are identified and corrected. [Section 1370, Rule 1300.67.3(a)(2), Rule 1300.70(a)(1), Rule 1300.70(b)(1)(A) and (B), and Rule 1300.70(b)(2)(E)]

The Plan does not have an orthodontic consultant to conduct quality assurance reviews of offices providing orthodontic services to Plan enrollees (see "Plan Organization", above). The Plan does not have a written QA Program for orthodontics, and has not conducted any QA activities for its orthodontic providers. The Plan has not developed an orthodontic quality of care assessment instrument for office chart reviews.

During the Department's interviews, Plan staff indicated that they did not feel there were enough patients in treatment to warrant a quality of care chart review. There were, however, several practices which had a significant number of patients who had received or were currently receiving orthodontic treatment. One provider had 20 patients in active treatment and eight completed cases; a second provider had ten patients in active treatment and four completed cases; and a third provider had ten patients in active treatment and three completed cases.

CORRECTIVE ACTIONS:

The Plan shall submit a corrective action plan, including a revised Quality Assurance Program description that provides for on-site audits of the offices that provide orthodontic services to Plan enrollees. The Plan's submission shall include a description of the Plan's audit methodology, a copy of the orthodontic chart audit instrument and standards by which the Plan shall determine whether orthodontists provide a level of care consistent with professionally recognized standards of care;

The Plan's submission shall include an audit cycle that sets forth the on-site audits, which shall include chart review, for each of the Plan's participating offices that have a threshold level of Plan enrollees in orthodontic treatment. The Plan's audit schedule shall demonstrate this activity shall be conducted on a sufficiently frequent basis to ensure that a level of care meeting professionally recognized standards of practice is being delivered to Plan enrollees. The Plan's submission shall include provisions for re-audit within a reasonable time period for offices which are significantly non-compliant with professionally recognized standards of practice as determined by the Plan's orthodontic auditor. If the Plan retains a current orthodontic provider to conduct the orthodontic Q.A. audits, the Plan's submission shall describe how that provider's office will be evaluated.

The Plan's revised Quality Assurance Procedures shall also provide for review by the Plan's orthodontic auditor of any complaint concerning the quality of orthodontic services filed by a Plan enrollee.

Plan's Compliance Efforts:

The Plan states in its response that the numbers of active and completed patient cases at three orthodontic providers that were provided to the Department were overstated estimates, and upon re-querying the providers, the Plan was informed that the actual numbers were significantly lower. The Plan's response includes copies of the relevant correspondence. While the original estimates of active and completed cases for one of the orthodontic offices were 20 and 8, respectively, the numbers of cases determined on follow-up were 4 and 0, respectively. While the original estimates of active and completed cases for another orthodontic office were 10 and 4, respectively, the numbers of cases determined on follow-up were 4 and 0, respectively. While the original estimates for active and completed cases for yet another orthodontic office were 10 and 3, respectively, the provider acknowledged that he guessed, and asked that his original reply by voided, but provided no actual revised numbers.

The Plan's response also sets forth the following regarding the Department's findings:

> "The Plan believes that with the low levels of enrollment and with the limited amount of time it has been operating under the new ownership, there are few members in active orthodontic treatment and even fewer, if any, that have completed treatment.
>
> Nevertheless, the Plan has contracted with an orthodontist who is CADP certified to conduct orthodontic Quality Assurance Activities, including office audits. See the Plan's response to item #1 for background and qualifications. The Plan has adopted and adapted the CADP orthodontic Q/A assessment instrument for office chart reviews and has revised its audit policy in its QA plan to include orthodontic audit policy and guidelines, including audit methodology, standards and audit cycle, including re-audits. See the enclosed red-lined copies of section VI and VII of the Plan's Q/A Plan.
>
> The plan's orthodontic auditor is not a participating orthodontic provider.
>
> Enclosed is a red-lined copy of the Plan's member grievance flow chart that reflects the involvement of the Plan's Orthodontic Auditor, or Q/A Consultant."

Section VI., "Chart Reviews," of the Plan's revised QA plan states, in part, the following regarding the Plan's chart selection criteria for orthodontic offices:

> "Orthodontic audits will be performed in offices with a sufficient number of members with active and/or completed treatment.
>
> The Plan will annually query the orthodontic offices to try to determine the number of names of members receiving treatment. Any additional information that indicates orthodontic activity (such as requests by orthodontists to verify eligibility) will also be used to determine activity. When five members are confirmed to be in active or competed treatment, an orthodontic audit will be scheduled. The orthodontic Quality Assurance auditor will perform a facility audit and will review a minimum of five plan charts."

Department's Findings Concerning Plan's Compliance Efforts:

The Department finds that further revision of the Plan's CAP is necessary in order for the Plan to ensure that the CAP is capable of correcting this deficiency, as described below.

Corrective action for this deficiency is not adequate until the Plan develops a method to accurately determine which of its members is receiving orthodontic treatment and in whose offices they are receiving treatment. Although the Plan demonstrated that information the Plan supplied to the Department to evaluate orthodontic enrollment was in error and that the orthodontic enrollment was much lower than the original information indicated, the Plan's response provides evidence that the Plan still does not know which or how many of its members are in orthodontic treatment, and has no method to track enrollees in orthodontic treatment. The Department notes that the orthodontic benefit is a reduced orthodontic fee schedule and does not require Plan authorization. A letter included in the Plan's response from an orthodontic provider indicated that since there are no claims paid or authorization procedures, the provider is unable to track the Plan's patients.

The Department finds that the Plan has not adequately responded to the Department's request for corrective action and that it will take additional time beyond the date of the Plan's response for the Plan to correct this deficiency and to fully implement and document the changes required by the Corrective Actions.

Deficiency 4: The Plan did not have an appropriate range of dental specialist providers involved in quality assurance activities or on QA review committees. [Section 1370 and Rule 1300.7(b)(2)(E)]

The Plan did not have any dental specialists involved in quality assurance activities. There were no specialists involved in the Quality Assurance or Peer Review committees.

CORRECTIVE ACTIONS:

The Plan shall submit a corrective action plan which includes evidence that it has arrangements with specialty dental providers to participate in quality assurance activities as necessary and also includes their participation in QA and Peer Review committee meetings and QA policy making.

Plan's Compliance Efforts:

The Plan states in its response that it has revised its QA and Peer Review committees to add a dental specialist of each of the following types: orthodontist; periodontist; pedodontist; endodontist; and oral surgeon. In addition, the Plan's response includes Section II., "Oversight and Component Committees," of the Plan's revised QA plan, which provides for the participation of dental specialists in the Peer Review Committee, as well as in the QA Committee activities on a rotating basis. The Plan's response also sets forth the following:

> "The goal is to have at least one representative from each specialty (orthodontics,

> periodontics, pedodontics, endodontics and oral surgery) available for QA and peer review as well as consultation as needed for grievance issues. Specialists will attend Quality Assurance and Peer Review meetings on a rotating basis and/or be available via phone conferencing as needed. All committee members will receive copies of the minutes from each QA/Peer Review meeting regardless of attendance at the meeting. The Plan should have a specialist of each type within three months, and each of the specialists should have attended at least one Quality Assurance meeting by the end of this year, or approximately 6 months. The Dental Director . . . will be responsible for contracting specialists for Quality Assurance participation."

Also, refer to "Plan's Compliance Efforts" under Deficiency 1 regarding the Plan's addition of a designated Orthodontic Auditor who is directly involved in the Plan's QA Program.

Department's Findings Concerning Plan's Compliance Efforts:

The Department finds that the Plan's CAP is capable of correcting this deficiency. The Plan has made arrangements with an orthodontist, however it has not had time to complete arrangements with all of the other specialists.

The Department acknowledges that the Plan has taken steps to address the Corrective Action in the Preliminary Report. However, the Department finds that it will take additional time beyond the date of the Plan's response for the Plan to correct this deficiency and to fully implement and document the changes required by the Plan's CAP.

Deficiency 5: The Plan has not implemented a utilization monitoring system meeting Knox-Keene Act requirements. [Section 1370, Rule 1300.70(c), Rule 1300.70(b)(2)(H)2.]

The Plan's Quality Assurance Program describes how the Plan uses direct and indirect indices to monitor utilization of services, including direct measures based on encounter reporting and the payment of emergency and specialty claims. However, the Department found no evidence that the Plan has compiled utilization or encounter data for purposes of identifying patterns with utilization of services, including potential under-use of services by at-risk providers.

CORRECTIVE ACTIONS:

The Plan shall submit a corrective action plan, including the following:

(a) Evidence that the Plan has implemented reasonable procedures to monitor utilization and can demonstrate that utilization of services at the provider level are being evaluated by the Dental Director and Quality Assurance Committees; and

(b) Revised QA Program policies and procedures that include mechanisms to detect under-service by a capitated provider, including possible underutilization of specialist and preventive

health care services, and which assure the Plan shall take appropriate follow-up actions when the Plan monitoring detects possible underutilization or over-utilization of services by a provider.

Plan's Compliance Efforts:

The Plan's response sets forth the following regarding its utilization monitoring system:

> "The Plan has input all utilization encounter data received during the first quarter of this year and has produced the enclosed Utilization Report. This report indicates the number of procedures reported for each facility, by category or type of procedure (i.e. diagnosis, preventative, etc) and the percentage of each category to the total number of procedures reported. This report will be prepared quarterly and will be reviewed by the Plan's Quality Assurance Committee at each of its quarterly meeting. The Committee will develop threshold levels for significant deviation from Plan average that will be utilized for identifying over or under utilization.
>
> Enclosed are redlined copies of the revision to the Plan's Quality Assurance Plan that reflect the monitoring of utilization data."

In Section VIII., "Utilization Review," of the Plan's revised QA plan, the Plan states that it will monitor individual provider utilization data on a quarterly basis, comparing individual provider statistics with Plan averages and, where a threshold level of deviation is observed, the provider will be flagged for further investigation. The further investigation may include comparison to other utilization data (i.e., lab reimbursements, grievance tracking, specialty referral log) as well as contacting the provider for an explanation. The also states that the quarterly utilization data will be reported at the quarterly QAC meetings and, if a provider remains above or below the threshold for the same procedure group for a second consecutive quarter with no reasonable explanation, "a demand audit may be scheduled at the recommendation of the Dental Director."

The Plan's response also includes copies of utilization monitoring reports for its general dentists that it produced during first quarter 2001.

Department's Findings Concerning Plan's Compliance Efforts:

The Department acknowledges that the Plan has taken steps to address the Corrective Action in the Preliminary Report and has begun to implement the CAP. However, the Department finds that it will take additional time beyond the date of the Plan's response for the Plan to correct this deficiency and to fully implement and document the changes required by the Plan's CAP.

C. ACCESS AND AVAILABILITY

Deficiency 6: The Plan lacks arrangements that assure reasonable accessibility to dental care throughout the Plan's service area because the Plan lacks specialty providers in service areas in which the Plan is licensed to operate. [Section 1367(e)(1) and Rule 1300.67.2(e)]

The Plan lacks adequate arrangements with specialty dentist in the locations indicated below (also, refer to table below).

San Diego County: One endodontist in the county; no endodontist in the city of San Diego or from Fallbrook to the Mexican border; one pedodontist in the county and none in the City of San Diego.

Riverside County: No endodontists.

San Bernardino County: No endodontists.

Kern, Ventura, Santa Barbara, and San Luis Obispo Counties: No periodontists, oral surgeons or pedodontists.

Sacramento County: No periodontists, oral surgeons, orthodontists, or pedodontists.

Sonoma County: No periodontists, oral surgeons, or pedodontists.

San Francisco Bay area: No pedodontists or periodontists. There is one endodontist in the San Jose area.

County	Endodontist	Periodontist	Oral Surgeons	Pedodontist	Orthodontist
San Diego	1			1	
Riverside	0				
San Bernardino	0				
Kern, Ventura, Santa Barbara, San Luis Obispo		0	0	0	
Sacramento		0	0	0	0
Sonoma		0	0	0	
San Francisco		0		0	
San Jose area	1				

CORRECTIVE ACTIONS:

The Plan shall submit a corrective action plan, including evidence of executed arrangements with specialty providers in the counties where the Department's review found the Plan lacked arrangements for any of the following specialty services: endodontic, pedodontic, oral surgery, periodontic and orthodontic.

However, for counties where the Plan demonstrates that there are no specialty providers or that the only specialty providers in the county are unwilling to contract with the Plan, for each specialty for which the Plan lacks arrangements, the Plan shall respond as follows:

(a) If the Plan relies upon arrangements in adjacent areas for specialists, the Plan may submit a description of the specific arrangements the Plan has in place and demonstrate these afford reasonable accessibility to services and are consistent with patterns of practice; or,

(b) The Plan may alternatively provide documented evidence that the Plan has attempted, but has been unable, to obtain contracts with specialists in these locations and that the Plan commits to pay fee-for-service for specialty services in these counties. If the Plan chooses this method, it must submit evidence demonstrating the general dental providers in these counties have been informed of this referral policy; or,

(c) If the Plan has no general dental enrollment in any county where the Plan also lacks adequate specialty provider arrangements, the Plan may choose to submit an undertaking that the Plan shall file a material modification to delete any such county from the Plan's approved service area.

Plan's Compliance Efforts:

The Plan states in its response that it has filed "Undertakings" with the Department on 7/30/98 and 11/11/98 that stipulate the Plan will pay all billed charges of a non-contracting specialty provider in the event there is not a contracting specialist readily accessible to the enrollee. Copies of these "Undertakings" are included in this response. In addition, the Plan states that it requires each contracting general dentist to provide the Plan with a list of specialists to which he/she refers and that the Plan uses this list for both referring patients in areas where the Plan does not have dental specialist and as a prospective list for recruitment of dental specialists. The Plan states that it notifies general dentists of its policy to cover services at non-contracting specialists in specific counties, where applicable, upon general dentists' submission of specialty referral authorization requests. The Plan's response also states that, "as a part of the Department's Financial Examination in July 2000, the Department's Financial Examiners requested and received copies of paid claims that demonstrated the Plan was paying dental specialists on a fee-for-service basis in areas where the Plan did not have contracting dental specialists."

The Plan submitted with its response a copy of its "Referrals" policy (also Exhibit I-6 of the license application in which the Plan states the following:

> "The Plan's experience is that specialists are very reluctant to contract with dental plans until the plan has demonstrate that they have patients to refer to the specialists and proven themselves by authorizing referrals and paying claims timely . Even then, many specialists still will not contract with dental plans, although they will accept referrals from plans and look to those plans for payment.
>
> Therefore, the Plan is committed to work with local specialists to establish this credibility and to eventually obtain contracts with many more specialists. In areas where the Plan does not have contracts with needed specialists, the Plan will look to the member's general dentist for a recommendation of specialists. The Plan will then contract the specialist to make sure that they will agree to treat the Plan's member and bill the Plan for the services. The plan will pay the specialist on a fee-for-service basis, and will attempt to obtain discounts wherever possible."

Department's Findings Concerning Plan's Compliance Efforts:

While the Plan's response to the Corrective Action addresses, in part, how the Plan will ensure reasonable access to specialists in counties where the Plan's lacks direct contracts with specialists, the Plan's response lacks evidence of the Plan's solicitation efforts to contract with specialists in the counties cited in accordance with its submitted Referral policy.

The Department acknowledges that the Plan has taken steps to address the Corrective Action in the Preliminary Report. However, the Department finds that it will take additional time beyond the date of the Plan's response for the Plan to correct this deficiency and to fully implement and document the changes required by the Plan's CAP. The actual availability of specialists in the counties in question will be further assessed at the time of the Follow-up Review.

SECTION VII. ADDITIONAL FINDINGS AND RECOMMENDATIONS FOR CONSIDERATION

Finding 1: The Department found that the Plan had not implemented its "Member Surveys" in accordance with its QA Program description.

Recommended Action:

The Department recommends that the Plan initiate implementation of its surveys and the QA Committee review the survey results and that the results are incorporated into the Plan's QA process.

Finding 2: The Plan's Quality Assurance Program did not demonstrate an adequate process to ensure that all the dentists under contract to the Plan who provide services to Plan enrollees are licensed or certified where required by law. [Section 1367(b), Section 1370, and Rule 1300.70(b)(1)(A) and (B)]

The Plan credentials and recredentials all principal dentists with the Plan and uses a form "Confirmation of Staff Credentialing" to assure licensure of the associate dentists who work in the practice and provide care to Plan enrollees. The form is signed and dated by the principal dentist. However, the Department found several cases where the principal dentist failed to obtain evidence of current licensure. It is the responsibility of the Plan to assure or oversee that licensure of all dentists and associate dentists who render care to Plan enrollees is accurate.

The Department reviewed a sample of 13 provider files. Ten of the files were randomly chosen and three were the offices selected for chart audit during the Department's survey. In general, the files were not up-to-date. A number of files contained expired licenses; associate dentists listed, but not credentialed; credentials for associates not listed as dentists in the practice and, frequently, a statement signed by the principal dentist that testified all personnel who required licensure had current valid licenses.

Of the 13 provider files reviewed, three had up-to-date credentialing; four files contained expired dental licenses of the primary provider; five files contained a total of 13 listed associates who did not have evidence of dental licenses or the licenses had expired, and one file contained current credentialing for a provider who was not listed as a provider in that practice.

Recommended Action:

The Department recommends that the Plan submit evidence that the Plan has credentialed or re-credentialed each Plan dentist who provides services to Plan enrollees, which shall include the associate, as well as contracting, dentist (s) at participating Plan dental offices. The Department also recommends that the Plan establish mechanisms for assuring the Plan is informed when participating Plan offices add or delete associate dentists and has ready access to verification of professional license as required by Section 1367(b).

Plan's Response to Recommended Action:

The Plan response sets forth two alternative approaches for its credentialing and recredentialing of participating dental providers, summarized below, each of which addresses the credentialing of associate dentists at participating dental offices. The Plan states that its preference is to implement Alternative #1 due to the fact that Alternative #2 requires the Plan to restructure its provider contract files and redesign its provider database, and requires extensive time to implement, approximately six months. In addition, the Plan states that Alternative #2 would require substantially more time and staff to maintain.

Alternative #1:

> "The first alternative, which is the Plan preference, is to require the owner dentist to report all associates to the Plan. The Plan would then verify the associates license status with the California State Board of Dental Examiners via their on-line system. Any dentist with a problem license would be reported back to the owner dentist and restricted from treating Plan members. However, the Plan would prefer to delegate to the owner dentist the requirement of ensuring the associates have current malpractice, DEA and CPR since he or she, the owner dentist, is liable for the treatment provided by the associate dentist. Remember the associate dentists are agents or associates of the owner dentist and they have no contract directly with the Plan. Whenever the Plan requests credentialing information from the owner dentist, it would also request an updated list of the names and license numbers of all associate dentists in the practice, along with an affidavit that the owner dentist has verified that the associate's license, malpractice, DEA and CPR are current. The Plan will again check the licensing status of these associates at the time it re-verifies the license status of the owner dentist. When conducting facility site visits (Q/A Audits), the Plan will inspect these documents for each associate to ensure that the owner dentist has complied with these requirements. This shortens the requirements for dental offices to report new associates and simplifies the overall credentialing process, which should result in better and more timely responses from offices to the Plan's requests for updated credentialing documents. To implement this alternative, the Plan will need about 60 to 90 days to prepare revisions to its Quality Assurance Plan, obtain the updated list of associates and affidavit from each office and confirm the license status of each associate with the State Board of Dental Examiners."

Alternative #2:

> "The second alternative is for the Plan to revise its entire provider filing system and database, so that each individual dentist would be credentialed separately. This alternative process would require the following changes to implement:
>
> 1. Restructure the Plan's provider contract files
>
> The Plan will separate the facility information for each dental office from the provider credentialing information for each dentist practicing at that location. Facility information files will contain the provider contract, the facility information summary and

any facility inspection reports. The Plan will than create a separate provider credentialing file for each dentist, based upon their license number with the California State Board of Dental Examiners. Each facility file will contain the name and license number of the owner dentist and each associate dentist that practices at that location. Each dentist credentialing file will have the facility numbers for each location where the individual dentist practices.

2. Redesigned Provider Database

The Plan will create a new provider database to maintain a history and background on each individual provider, along with the renewal dates for each of the Credentialing requirements. The Plan will also have to modify its existing database to create references for the names and license numbers for all the associates practicing at each location.

3. Update Associate Listing

Upon Department approval, the Plan will send out with the next month eligibility and capitation rosters a notice to all owner dentists to remind them associate dentist many not treat Plan members unless and until they have been credentialed with the Plan. The notice will also request an update of the list of associate's dentist practicing at their location. The notice will also inform each owner dentist that the Plan may withhold all or a portion of the facilities monthly capitation if it does not receive updated credentials in a timely manner.

4. Re-credential Associates

The new system/database will enable the Plan to identify the expiration dates for each of the dentist individually, whether they are an owner or an associate dentist. The Plan will send out requests for updated credentialing material for each dentist based upon their individual expiration dates."

The Department finds the Plan's response to the Recommended Action is thorough and addresses the issue raised in the Finding. The Plan may delegate the responsibility of ensuring valid credentials for associate dentists who treat Plan enrollees to the primary contracted dentist so long as the Plan adequately oversees this process. According to "Alternate #1" the Plan will require the owner dentist to report all associates to the Plan. The Plan will then verify the associate's dental license status with the California State Board of Dental examiners via their on-line system. The Plan would delegate to the owner dentist the requirement of ensuring the associates have current malpractice, DEA and CPR. The Plan's primary mechanism to oversee this partially delegated process is the Plan's inspection of associates' documents at contracting dental offices during the periodic QA facility reviews wherein the Plan will verify principal dentists' compliance with the Plan's requirements.